



# LATENT TUBERCULOSIS INFECTION (LTBI) REPORT FORM

## SOUTH DAKOTA DEPARTMENT OF HEALTH

### REPORTABLE TB RISK FACTORS (check all that apply)

Please only report patients with latent TB infection who have at least one of the following risk factors:

- |  |  |
|--|--|
| <input type="checkbox"/> Foreign-born persons who entered the US within last 5 years   | <input type="checkbox"/> Diabetes              |
| <input type="checkbox"/> Persons evaluated for tumor necrosis factor-alpha therapy   | <input type="checkbox"/> Renal dialysis        |
| <input type="checkbox"/> Immunosuppressive therapies   | <input type="checkbox"/> Silicosis             |
| <input type="checkbox"/> Radiographic evidence of prior TB   | <input type="checkbox"/> Organ transplant      |
| <input type="checkbox"/> Children less than 5 years of age   | <input type="checkbox"/> Head and neck cancers |
| <input type="checkbox"/> HIV infection   | <input type="checkbox"/> Leukemia              |
| <input type="checkbox"/> Close contact (Defined as confirmed exposure in the last 12 months)<br>(Name of TB source case must be documented in Section 2 below) | <input type="checkbox"/> Hodgkin's disease     |

Report by fax: (605) 773-5509

Report by mail: Tuberculosis Control Program  
South Dakota Department of Health  
615 East 4<sup>th</sup> Street  
Pierre, SD 57501

TB Program questions: 1-800-592-1861 or  
(605) 773-3737

### 1. PATIENT DEMOGRAPHICS

Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
Address \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ County \_\_\_\_\_  
Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ Cell phone \_\_\_\_\_  
Parent/Guardian \_\_\_\_\_ Employer \_\_\_\_\_ Telephone # \_\_\_\_\_

**Gender**  
☐ Male ☐ Female

**Race**  
☐ White ☐ Native American ☐ Black ☐ Asian

**Ethnicity**  
☐ Non-Hispanic ☐ Hispanic

Foreign Born: ☐ No ☐ Yes If yes, country of birth \_\_\_\_\_ Date of entry into US \_\_\_\_\_  
\*(Required if foreign-born)

Clinic Name \_\_\_\_\_ Telephone # \_\_\_\_\_  
Physician \_\_\_\_\_ Fax # \_\_\_\_\_ Patient Weight \_\_\_\_\_ Lbs.

### 2. TB SCREENING INFORMATION

Screening test: ☐ **TB skin test**  
Date of test \_\_\_\_\_  
Result: \_\_\_\_\_ mm

☐ **IGRA (Interferon Gamma Release Assay)**  
Date of blood collection \_\_\_\_\_  
Result: ☐ Positive ☐ Negative ☐ Indeterminate

Classification: ☐ Reactor  
☐ Convertor Date of last negative test <2 years ago \_\_\_\_\_ mm  
☐ Contact Name of TB case that exposed patient \_\_\_\_\_

### 3. CHEST X-RAY INFORMATION

Date of the chest X-ray \_\_\_\_\_ Results \_\_\_\_\_

### 4. TREATMENT INFORMATION

Starting Treatment? ☐ No, Reason why \_\_\_\_\_ ☐ Yes, Date started \_\_\_\_\_

Therapy Prescribed:

<input type="checkbox"/> INH and Rifampine (3HP)	Once weekly for 12 doses (3 months)
<input type="checkbox"/> Rifampin	Daily for 4 months
<input type="checkbox"/> Isoniazid (INH)	<input type="checkbox"/> Daily or <input type="checkbox"/> Twice weekly <input type="checkbox"/> 6 months or <input type="checkbox"/> 9 months
<input type="checkbox"/> INH and Rifampin (3HR)	Daily for 3 months
<input type="checkbox"/> Vitamin B-6	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Twice weekly <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months <input type="checkbox"/> 9 months

Medication Provider:

☐ Department of Health (Name & Location) \_\_\_\_\_  
☐ Other facility (Name, Location & Phone) \_\_\_\_\_